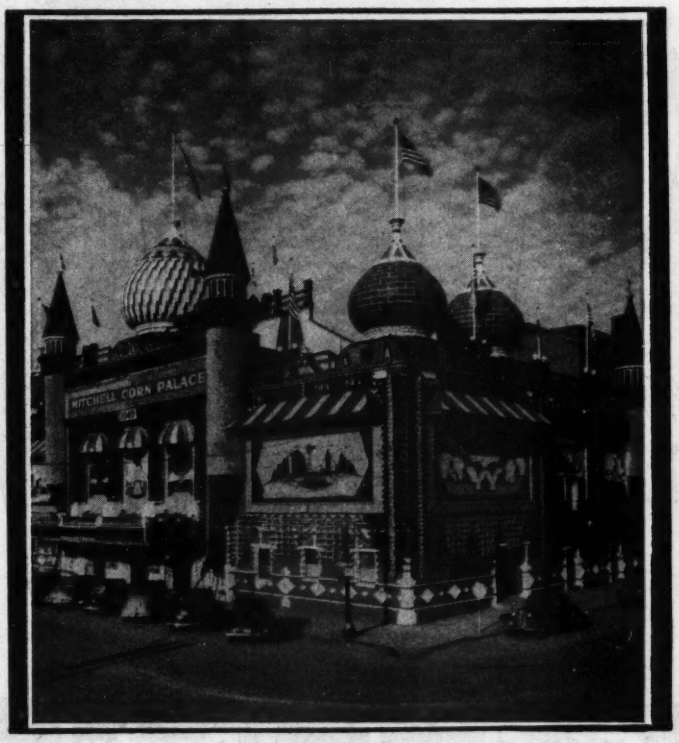
Oral Hygiene

MAY 1952



Corn Palace, Mitchell, South Dakota. Annual meeting of the South Dakota Dental Society will be held in Mitchell, May 18-20.

In this issue: *"Don't Make the Same Mistake—Once"*

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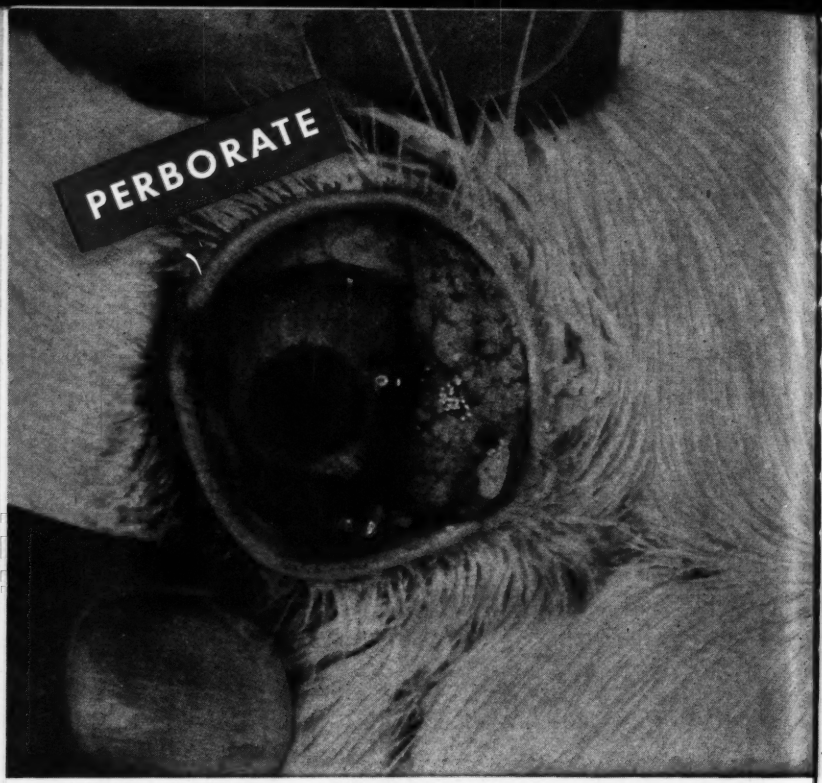

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* Best and Taylor, Physiological Basis of Medical Practice, 5th Ed., 1950, Williams & Wilkins, p. 494.

Picture of the Month

A DENTIST whose hobby is masonry evokes much interest in his community. This talented brickmason is Doctor Philip L. Schwartz of New Brunswick, New Jersey. He is shown here building a wall around part of his garden with the help of his son.

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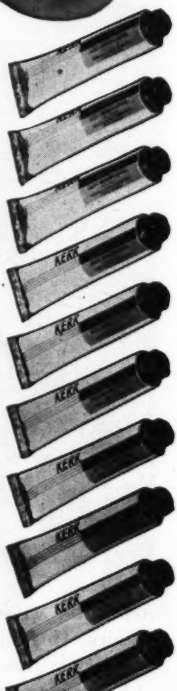

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ACCEPTED STANDARD FOR ACCURACY IN THE PROFESSION

Don't Make the Same Mistake . . . *Once*

BY LEE A. KAPILOW, D.D.S.

Hidden risks in the dental office are plentiful—take time for extra precautions.

BECAUSE OF the nature of the area in which dentists work, the problem of precaution against accident is constantly with us. The mouth with its pliable, slippery walls, active tongue, and drenching saliva, presents a workshop that is inherently dangerous. As students, these facts are made abundantly clear to us. The teaching of proper finger positions, guards, and rests, forms the ABC's of our education —foundation stones in the structure of good operative procedure. As a result of this emphasis on care, the more common mishaps such as slipping instruments, jamming separating disks, and wandering burs, are prevented to a considerable degree when the student becomes the practitioner.

But does this mean that the ordinary precautions that we have been taught and now practice instinctively are enough to insure us against all mishaps? Decidedly not, for accidents of almost any conceivable nature will occur from time to time despite taking what we consider adequate care while operating. We are well prepared for the known and common, but the unknown, the new, and the startling can catch us off guard.

Each of the many aspects of dental practice is fraught with possibilities of danger. The consequences of these possibilities may seem unbelievable to those who have never suffered from them, but they are quite believable to those

who have. These consequences do not have to be serious in order to cause grief, annoyance, and frustration to the dentist and patient involved.

Freak Accidents

One example of these unexpected circumstances is the situation of the dentist who has just completed an inlay preparation. He hangs up his contra-angle and, as he turns to procure a temporary dressing, his knees turn to jelly when the patient emits an anguished cry. To his horror, he discovers that the angle that he thought had been hung carefully on its hook has fallen and plunged the appended bur, coated with oral bacteria, into the back of the patient's hand. Now the dentist has a problem of two dressings—one for the tooth and one for the hand—and a possible law suit as well!

A case such as this was reported in the literature some time ago but with far more disastrous results. In this case, the bur plunged not into the hand but, in some unaccountable manner, into the base of the brain—and caused the death of the patient. An unforseen and unfortunate turn of events? Surely! But it can happen easily if we do not insure against it by pushing the engine arm well out of the way when we finish with it.

As another illustration of the unexpected, imagine that the dentist has decided to take a copper band impression of his inlay preparation. He is engaged in casual conversation with his young woman patient as he melts the stick compound over his bracket burner. Suddenly, a hot drop escapes and falls on the patient's leg, not to mention the damage it does to a pair of nylons. Is such an accident commonplace? Not at all. But it has happened and can be avoided so easily by getting the bracket burner out of range of the patient.

While on the subject of legs, we might well mention a chilling sight that has taken place in more than one dental office. Nothing is quite so heart arresting as watching your patient's legs suddenly shoot out from under him as he steps from the chair. Equally unfunny, but perhaps poetically just, is having this happen to the dentist. How is this managed? Just do a good deal of trimming on an acrylic denture right at the chair and let the filings fall where they may. Acrylic filings on a waxed linoleum floor make a combination as slippery as a skating rink. Trim your dentures on a laboratory lathe or have the filings swept away immediately.

Incidentally, when you speak of dentures, duck! The mishaps in this phase of dental practice can come shooting at the unwary like buckshot. Luckily, most misadventures involving dentures are not serious, but they certainly can be annoying. One sure way to get off on the wrong foot is to attempt to insert the wrong denture! This may occur readily if you are in the habit of

lumping all your finished dentures in one jar of water—waiting to be fitted to their various owners. Sometimes two full upper dentures look similar enough to be confused and the careless dentist may find himself trying to insert the wrong one. And it is even worse when he starts to trim it because it won't slide over a bulging tuberosity the way he thinks it should!

Partial Denture Mishaps

Partial dentures may offer a myriad of sources of trouble—some grave, others not—but all guaranteed to be vexing. Is it possible, for example, to catch a bit of cheek or even the papilla of Stenson's duct between a clasp and abutment tooth when trying in a new upper partial? It certainly is—and the resulting laceration may be painful for days!

Clasps may be caught in other areas as well, particularly on rag wheels when a finished appliance is being polished. The denture then leaves the hands at an amazing rate of speed. When it is reclaimed from the floor or laboratory bench to which it is thrown so forcibly, there is cause for celebration, indeed, if it still fits.

We have all experienced occasional difficulty in inserting a new partial denture, particularly if the abutment teeth are inclined considerably. When we have it almost in place, there comes over us a tendency difficult to control. Just push a little bit harder and in it goes! But will it come out? Usually not—and we can well imagine the patient's thoughts as he wonders how he will ever get the darned thing out, if it takes the dentist fifteen to twenty minutes to pry it loose. Take another five minutes to relieve the undercuts rather than a half-hour to explain them. It is much easier!

Finally, be explicit in your instructions to new denture wearers. Take it for granted that the patient will try to adjust the denture himself. Many patients, particularly those who have some degree of pride in their mechanical ability, attempt to relieve real or imagined sore spots by trimming their new dentures. Tell the patient specifically and forcefully that he is not to attempt to alter the denture in any way. Then you won't be treated to the sight of a mangled appliance being returned at the next visit of the self-appointed prosthodontist.

In regard to instruction, make certain also that the patient understands that "keeping the socket clean" following an extraction does not include removal of the blood clot as well as food debris. People have taken dentists at their word and have carefully swabbed out well organized clots in an effort to be cooperative. Dry sockets take a long time to treat and the time seems even longer when they are induced artificially.

Patients' lips are areas which are particularly prone to accident, being burned, cut, crushed, and otherwise put upon under odd circum-

stances. For instance, an attempt to pull a protective aluminum shell from an upper tooth with a sharp instrument often results in a gashed lower lip because of the softness of the aluminum. Slip! Oops! Sorry!

Crushing the lip against the lower teeth with a forceps while extracting an upper is almost too common to include here; but a rather novel way of burning the lower lip while phenolizing a cavity in an upper tooth is worthy of mention. This can occur through the capillary action provided by the near-closed arms of a college plier which pulls the caustic from the soaked cotton pellet which, in turn, burns the lower lip, where the instrument often is allowed to rest.

Further Risks

It should be mentioned that it is possible to break a patient's glasses with the focusing cone of the X-ray machine as it is swung from one side of the chair to the other, if the glasses are not removed, as they should be.

It is also possible to cement a cotton roll under a bridge abutment such as a full crown. The protruding tassel of cotton remaining when the bulk of the roll is removed may be quite decorative, but it is hardly conducive to longevity of the bridge. Naturally, the lingual cotton roll should be cleared always when the bridge is forced to place.

Tongues, which are partly anesthetized by mandibular injections, may be caught in the lingual beak of a forceps by the unwary dentist. And upper anteriors may be fractured readily by the arms of a lower forceps as a recalcitrant molar suddenly gives way.

Finally, to conclude this compendium of horrors, which, for obvious reasons, is by no means complete, a contra-angle which has become unknowingly "frozen" may start to spin about violently in the mouth if it is not tested before the bur is applied to the tooth. The ensuing damage is not likely to be inconsequential.

Is some of this difficult to believe? Does it sound as if it were made up of whole cloth and a strong dash of imagination? Sadly enough, it is all true, because each of the mishaps detailed in this article has occurred in the office of some practicing dentist, my own included.

I believe that the victims of these situations are, on the whole, as careful and conscientious as any representative group of dentists in the country. And I am convinced that any reader of this article can point out a duplicate circumstance

(*Continued on page* 732)

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ORAL HYGIENE AWARD

This article by LEE A. KAPILOW, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

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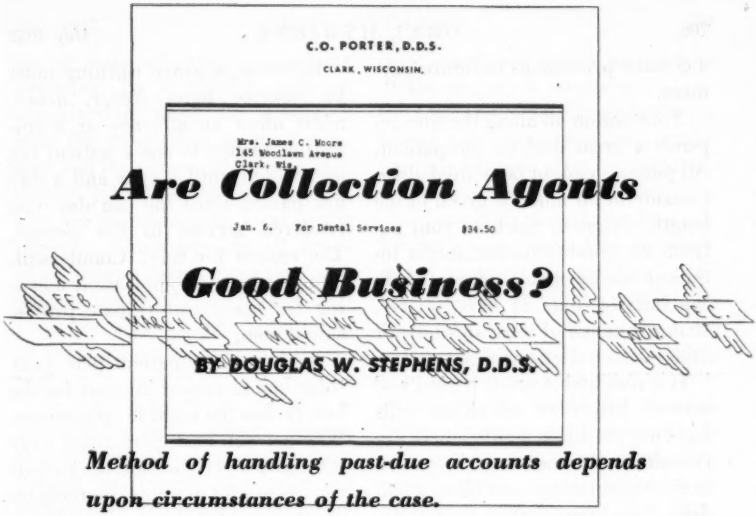


Are Collection Agents Good Business?

BY DOUGLAS W. STEPHENS, D.D.S.

Method of handling past-due accounts depends upon circumstances of the case.

AT SOME time or another, even in the most efficiently operated dental practice, a practitioner will find overdue accounts that do not respond to ordinary collection procedures.

The question then arises, "What shall be done with such accounts? Is it proper to take them to court, send them to an attorney, or refer them to a reliable collecting agency?" In any case, a great deal of money is lost—at least half of what is collected.

We realize most accounts should not be allowed to go this far, but sometimes they do despite all the precautions taken. If we have sent out three notices—the original statement and one each thirty days for two successive months—the account will be sixty days old and definitely past due.

Experience has shown that, as accounts age, they become more difficult to collect and losses are higher. It is said that a current account dollar shrinks to ninety cents at the end of three months, to fifty cents at the end of six months, and to thirty cents at the end of a year.

For this reason it is best not to wait over sixty days before taking some definite action. The first step should be in the form of a friendly letter or a personal telephone call by your secretary. The latter method is best, for often the letter is tossed into the waste basket unopened. On the other hand, the telephone call immediately brings forth a reason for nonpayment with

a definite promise as to future payment.

Your action all along the line depends a great deal on the patient. All patients cannot be treated alike. Consideration must be given to the length of time he has been your patient, the conditions that might influence his payment; an approaching harvest, date of next payday, strikes, change of jobs, sickness, or other personal exigencies.

If a reasonable grace period and several letters or telephone calls have not produced results, there are two alternative measures. First, you may charge the account off as a bad debt. This necessitates closing the account; that is, giving no further service to the patient or his family, and blacklisting him with the local credit bureau if your town has such an organization. Second, you may turn the account over to an outside collection specialist.

In general, collection specialists may be classified as attorneys and collection service agencies.

Reliable attorneys have many advantages as agents for collection. For one thing, they are available throughout the country in almost every town—large or small. They will handle the letters and telephone calls and, when necessary, threaten or actually bring suit in an effort to collect your account. Some people who owe bills will pay them immediately when faced with a strongly worded letter from an attorney, yet they would pay no attention to the pleas of the dentist.

However, a grave warning must be inserted here. *Never, never, never* allow an attorney or a collecting agency to sue a patient for an account until a year and a day has passed since the last day you rendered service to the patient. The reason for this? Countersuit. The word has an unpleasant meaning for many unfortunate professional men.

As soon as a patient gets your subpoena to appear in court for the bill, he has the right to countersue. Whether you have performed your services properly or not, the patient can cause a lot of unpleasantness by dragging you into court on a countersuit. Sometimes they even trump up malpractice charges which, although they may not stick, cost you many times the face value of the account in money, worry, and time out of the office. Whenever you give out an account for collection, it is usually best to have it in writing that you do not wish the case to be brought to court unless you give your written consent. If you have not treated the patient for a year and a day, in most states he cannot countersue.

Attorneys, however, may be a disadvantage in the case of patients whom you wish to serve again on a cash or pay-as-you-go basis after the account is collected. An attorney might alienate this type of patient from your practice. In these accounts a collection agency may be more helpful.

In most communities of any size

one or more collection agencies are available. To be helpful, such an organization must be equipped with the tools; that is, the know-how and the personnel to do a successful job. Most collection services are affiliated with local credit bureaus, which provide all available information regarding the debtor, frequently using it to convince the debtor of the importance of maintaining a good credit record.

A collection service usually is connected with other agents throughout the country. If your patient has moved, the collection service can trace him and a personal call by an affiliated agent in the other city will be made.

Most collection agents have standard rate schedules. These should be studied to determine if it is worthwhile to put the case up for collection. Most collection agencies will handle small accounts as well as the large ones, and this is an advantage over an attorney who, in most cases, will handle only large accounts.

The fees of most reliable collection services are not excessive and are based on the age of the account. Collection statistics show that it costs more to handle the older accounts.

In the long run, it will usually be found profitable to place most overdue accounts with some sort of an outside collector even if only a part of the money is recovered. A patient who owes you money is less a friend than one who has finally paid his bill even after much threatening.

All accounts turned over to a collecting agency should be acknowledged promptly. If requested, periodic reports should be part of the service.

All agencies are not reliable, honest, and efficient, and certain qualifications should be checked before trusting your accounts to such service. The financial position of the service can be checked with your local bank. Usually, the Chamber of Commerce and prominent merchants can give you a reliable report on the reputation of the agency in your community. It is well to check the length of time the service has been in business and something of the agency's ethics in handling debtors.

The managers should be people whose integrity is not questioned and who are well known in the community.

No method is perfect when it comes to handling debts. However, when confronted with past-due accounts, it seems good business to follow the course of successful businessmen and use the tools of collection that fit the case best.

823 *Atlantic Avenue*
Long Beach 13, *California*

"Can You Guarantee Your Work, Doctor?"

BY JACK F. CATHCART, D.D.S.

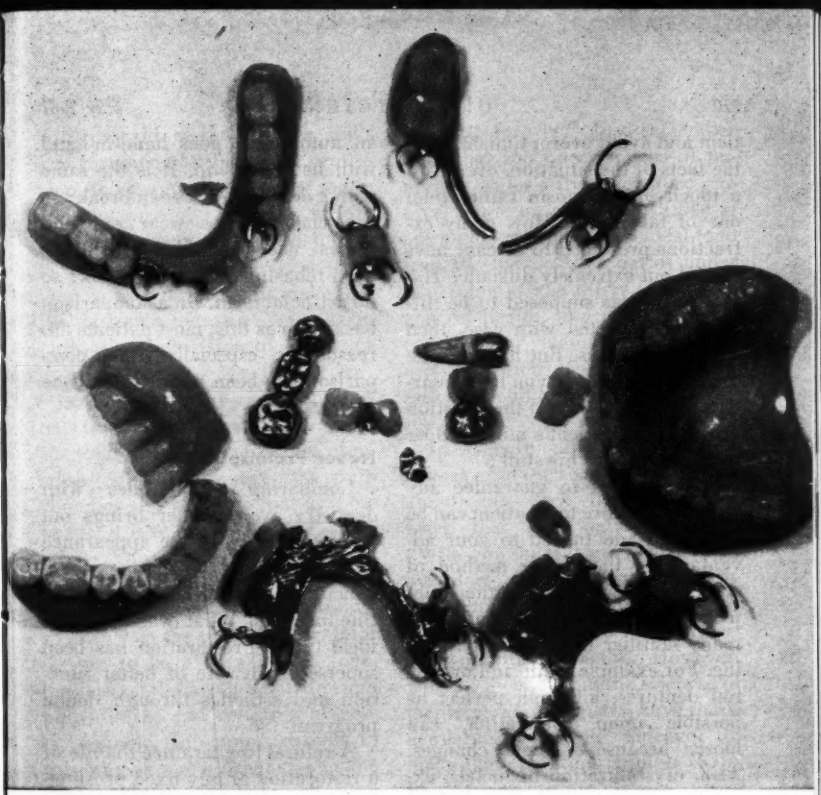
Besides being unethical, dental warranties risk the loss of patients' confidence.

THE WORD guarantee has become associated with nearly every piece of merchandise purchased by the American public. It even extends to many things we do, with the words "Money back" thrown in should we not appreciate the show we see or the things we eat.

How many of us stop to realize that the guarantee is worthless unless we check the person making it or study the fine print under the word, which many times nullifies the guarantee as we interpret it. Trying to make a guarantee stick is often impossible; yet the American public would rather have a guarantee on the guarantee than take the trouble to investigate what they really are purchasing for their money.

Buying merchandise that has a guarantee tag on it is one thing. But when you start trying to place that same tag on the human body, then you are heading for trouble. Moreover, the trouble does not stop with you; it carries over to others in our profession.

Not many days go by in a dental office without some patient asking, "Do you guarantee not to hurt, doctor?" or, "Will you guarantee my denture to fit?" or, "How long will you guarantee my filling (bridge, partial) to last?" Explanations take time, but now is the time to make them. The answers should be definitely negative, for, do not forget, Americans are accustomed to getting nearly everything else they purchase with that guarantee tag on it.



A dentist is offering his patients health, function, and esthetics to the best of his ability; not selling merchandise in the form of metal, plastic, or porcelain. The sooner the patient realizes that he is buying a service based on training and skill rather than a piece of merchandise, the sooner he will appreciate what the dental profession has to offer him. He will realize also that no one can guarantee services involving the human body, or even promise that his body will be alive tomorrow or the week after.

Fundamentally, people are honest and fair in their dealings with each other, provided there is no misunderstanding between them. To prevent misunderstanding, the dentist should, at the onset of any service for a new or old patient (but mainly the new patient), take the time to explain just how the procedure he plans to follow will affect that patient's welfare, discussing all possible sequences of the procedure. Be honest with the pa-

tient and avoid overoptimism. Face the facts of the situation, even with a touch of pessimism rather than one of false hope. How many extractions presumed to be easy have turned out extremely difficult? If a tooth that was supposed to be difficult is extracted with ease, then you are a genius. But have a little tough luck with one you have guaranteed to be easy, and the question arises in the patient's mind, "Does this fellow know his stuff?"

Your refusal to guarantee any dental procedure to a patient can be supported and turned to your advantage by the simple method of comparison with some other subject with which the patient is already familiar in his everyday living. For example, both full or partial dentures, although perfect as possible upon completion, can loosen because of tissue changes. Also, crystallization of metals, excessive stresses over a period of time, and accidents on the part of the patient cause breakage. How many of us have seen a fractured denture that obviously has been dropped, but was broken "by just eating a soft piece of bread."

It must be our fault as dentists that the general public expects prosthetic appliances to last a lifetime without necessary repairs or replacements. However, upon placement of a prosthetic appliance, comparison could be made between its upkeep and the repair and adjustments of an automobile. Everyone knows that the maintenance of an automobile goes hand-in-hand with its ownership. It is the same with a denture. Axles can break; so can clasps. Tires wear out and valves need grinding; dentures need rebasing. Windows break; so do artificial teeth. On a comparison basis such as this, most patients are reasonable, especially if the comparison has been made at the time of completion of their case.

Never Promise Results

Comparing automobiles with dentistry even further brings out the fact that, with the appearance of newer model cars, dentistry is advancing also in design and scientific benefits. What was once the ideal type of restoration has been superseded by one of better function and esthetics through dental progress.

A refusal to guarantee the life of a restoration or any fixed prosthetic replacement can be explained and justified by the dentist on another basis, also. The restoration or replacement would not be necessary had not a damaged condition of some type been present to necessitate this procedure. The deeper the cavity or the more broken the tooth, the greater the necessity for the replacement and, also, the greater the hazard of failure. Do not be afraid to anticipate possible failures to your patients. But do so before the treatment is begun; not after it is finished. The answer is always, "No two people react the same. I am doing all in my power,

with the aid of the modern skills and teachings of the dental profession, to save or replace your tooth. If I can save or replace it, we are justified in performing the job. It is always easier to extract a tooth than to save it, but let us make that the last consideration and, then, only as an admission of failure or as a final resort."

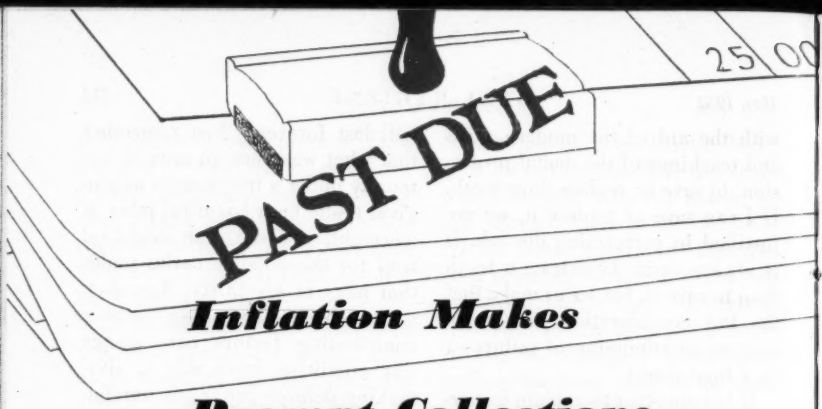
It is important to explain to parents that the pulp chamber is larger in a child's tooth than in that of an adult and, at any age, the pulp chamber size varies so that in some people it is relatively larger than in others. Subsequently, it is better to have a restoration come out and require replacement than to place it so deeply in the tooth that, while it is sure to be a "permanent" one, the loss of the tooth itself through pulp disease and resulting abscess is probable. Informing parents in this way is more beneficial to the dental profession than allowing them to acquire the attitude that, "while Doctor So-and-So's restorations might be coming out, mine will last forever." Just remember that what was once an area of immunity under a free margin of gingival tissue on a beautiful inlay at age eighteen, could be an ideal food trap for the possible caries under that inlay at age thirty. Age, diet, general health, and other variable contributing factors can change any condition from day to day, making definite prognosis unreliable.

In a sense, all dentists live in houses of glass, so let us be careful about any rock throwing. And when that next patient queries, "Will you guarantee not to hurt me, doctor?" just reply patiently that all pain is relative; what is painful to one person is not necessarily painful to another. However, with all the aids that the sciences of medicine and dentistry have made available, you will endeavor to make this operation painless to the best of your ability.

701 *American Trust Building*
Berkeley 4, *California*

THE COVER

THE CORN PALACE, shown on this month's cover, is trimmed every fall with corn, grains, and grasses to celebrate Mitchell's annual harvest festival. This unique civic auditorium, decorated permanently in red, blue, yellow, and white corn, is a symbol of the rich grain area in which it is located. It will be the scene of the annual meeting of the South Dakota State Dental Society May 18-20, 1952.



Inflation Makes Prompt Collections a "Must"

BY M. A. TRAVASCIO

"WITHOUT realizing it, some of my patients have been discounting my bills," an Eastern dentist remarked recently as he discussed changes he planned to incorporate in his billing and collection procedures.

While this may appear to be unusual in the payment of professional accounts, the practice is a daily occurrence and is shaving dollars from the incomes of dental practitioners throughout the country. Such "discounting" does not follow accepted commercial practices, but conceals the reduction in amount paid in a roundabout manner. For example, on the first of the month a dentist mails out a number of statements for professional services. In certain cases thirty, sixty, or even more days may pass before these charges are satisfied and, in the meantime, the costs of the dentist's personal, professional, and household articles have advanced. These inflationary hikes in living and operating expenses may require that he pay 2 per cent or 3 per cent more for these articles than he would have paid on the day the statements were rendered. Thus, for each per cent of increase in costs during the waiting period, the dentist suffers an equal loss of purchasing power from the overdue dollars. Without actually showing it, his bills are "discounted," and within a year these real but concealed losses may add up to sizeable sums.

If the consequences of inflation were a diminishing threat, the need

Steady rise in cost of living makes the extension of unlimited credit to dental patients prohibitive.

for a fresh review of dental collection practices might not be so vital. But the pronouncements of those who are supposed to know carry new warnings of "across the board" increases in the cost of products and services. Such promises add an extra degree of urgency to the need for dental practitioners to keep the period from chair time to pay time as short as possible.

The logical question that follows a careful analysis of these facts is simply this: What can and should the individual dentist do to keep his collections on a current basis? The answer is simple. Ask for the money that is due before it becomes increasingly difficult to collect. The patient feels he is being asked to pay for something and receiving nothing in return. This same lack of logical reasoning prompts some basically honest people with overdue accounts with one dentist to turn to another practitioner when in need of further dental service.

Why The Delay?

There was a time when the standard collection practice was to attempt to scare the lagging debtor. This method was tossed aside, not because men and women do not scare as easily today, but because "getting tough" was found to be a good means of losing not only regular visits from the debtor-patients but also the good will of their families and their friends. Also, there is an important financial consideration involved in the application of "last resort" collection methods. Frequently, this calls for the enlisting of outside assistance which automatically means that, when and if the outstanding bill or bills are collected, the amount the dentist receives will be reduced through the deduction of fees and other charges.

Invariably, there is some sound reason why most patients delay paying a bill beyond a certain period. In some cases, the money is simply not available and, when this is true, the practitioner then must wait for a correction of the cause of the delay. Not infrequently, the dentist can be of assistance in hastening such a correction if he suggests that the patient might find it practical to lump all his obligations into a single loan from a bank or finance company and thus extend payments over a relatively long period while reducing his monthly obligations. A friendly discussion with a patient along these lines may point out a practical avenue of escape from a multiplicity of bills and enable you to collect your overdue account.

It is not uncommon for a patient to look at his dentist's bill and lay it aside for future consideration with the comment, "He's got plenty; he can wait a while longer."

To combat this justification for delaying payment, one dentist addressed a letter to an overdue account with an opening paragraph that read like this:

> "Just last week I mailed a check to my dental supply house in payment for purchases made recently. Some of the materials I ordered were to replace those used while I was attending to your dental needs. That, as you may recall, was over six weeks ago . . . "

The attempt of this letter to put the need for more prompt payment on a personal basis succeeded in making the patient realize that the practitioner must meet bills for services and supplies also, and the payment of these obligations is possible only when his patients satisfy *their* obligations.

Try Friendly Approach

Since the use of the mails is perhaps the least costly and most effective collection stimulant at the dentist's disposal, the phrasing of the letters is of vital importance. Although the exact wording must vary in accordance with individual needs, the application of a friendly approach that brings the dentist and his patient into a man-to-man discussion of the matter almost invariably will lead to a quicker and more mutually satisfactory solution.

Frequently a few well-chosen words spoken while the patient is in the chair can be employed to create a more favorable acceptance of the dentist's bill when it is received. Such remarks, designed for those who do not pay following each visit, may include casual references to the charges made for the individual operations performed. In this way, the patient is furnished facts that permit him to calculate mentally the total charges for professional services for which he is obligating himself. Also, during such conversations, the dentist has an opportunity to build up a better understanding of his own problems during the current period of advancing prices. He may accomplish this through references to specific increases and, while mentioning exact costs is not always desirable, these comments will be equally effective if comparisons are made on a percentage rather than a dollar and cents basis.

It was following just such a conversation that one dentist and his patient arrived at a workable plan that kept the young woman from facing a bill that might be considered large when matched against her modest income. The dentist had estimated that four visits of one hour each would be required to correct her dental faults. Ordinarily, this practitioner would have arranged these visits a week apart but, during the discussion, the patient admitted willingly that the quoted charge would be too great to take out of one month's income.

The dentist then suggested an alternate procedure that spaced the visits to coincide with the semi-monthly paydays of the patient. The young woman agreed to the revised plan and paid a proportionate amount immediately following each visit. When the required dentistry was finished, the dentist handed her a statement and watched her pleased expression as she read the notation, "Paid in full." Incidentally, this woman patient has continued the "pay-as-you-go" plan and her dentist who suggested it has enjoyed dual benefits. He has eliminated at least one billing operation with its accompanying costs, and has rid himself of one possible loss through inflationary "discounting."

Actually, collecting under today's conditions calls for a positiveness of action. The dentist who feels that the patient in his chair may be inclined to allow a bill to run beyond its due date cannot be wishy-washy on the subject of money. Since the threat of an eventual delay may lead to no collection at all, he is within his right to suggest payment following each call, spacing calls to fit in with paydays, or setting up a schedule of weekly payments that will clear up the patient's obligation on or shortly following the final chair period. By suggesting a definite plan for payment, the patient is given a set of actions to follow. Some people respond more satisfactorily when told what is expected of them and when it is expected.

As mentioned previously, patients all over the country are discounting bills, unaware that they are inflicting a loss on their dentists. If you, too, have been unconscious of the leakage of dollars, take a minute tonight to match your outstanding accounts during the last year against the cost-of-living increases during the months the statements remain unpaid. Now, add up these 2 per cent and 3 per cent shrinkages. The grand total will probably startle you into applying some of the suggestions contained in this article that apply to your particular practice. A year from now the saving will put extra dollars in your pocket.

934 *North* 63*rd Street*
Philadelphia 31, *Pennsylvania*

COURT BARS FLUORIDATION

A TEMPORARY restraining order was granted recently by Judge Daniel D. O'Brien in the Superior Court in Springfield, Massachusetts, prohibiting the Northampton Water Commission from further fluoridation of water and preventing further "illegal expenditure of municipal funds" for the purchase of fluorine. Opponents of fluoridation seek an injunction until the voters have had an opportunity to express their views.—*New York Times.*

At Pearl Harbor, Admiral Chandler is briefed on conditions in Korea before leaving Honolulu. His advisor is Rear Admiral C. A. Broaddus (MC) USN, Pacific Fleet Medical Officer (right).

Naval Dental Personnel Under Fire in Korea

BY ALFRED W. CHANDLER
REAR ADMIRAL (DC) USN*

EXPERIENCE HAS proved that special training and qualifications are necessary for dental personnel to carry out their duties adequately when assigned to combat units with the United States Marines. All dental officers and dental technicians who are to be assigned with the combat "leatherneck" divisions are given an intensive 5-week course of instruction at one of the naval medical field service schools located at Camp Lejeune, North Carolina, or at Camp Pendleton, California. This course trains them for the duties they will perform and the various conditions to which

*Assistant Chief, Bureau of Medicine and Surgery and Chief of Dental Division.

Bureau of Medicine and Surgery officer reports on round-the-world inspection tour of dentistry in combat.

they may be subjected during combat and field duty.

Last fall, accompanied to Korea by Captain Clay A. Boland (DC) USNR, head of the reserve branch, and my administrative assistant, Lieutenant Commander J. J. Jacobs (MSC) USN, I made a 37-day round-the-world flight inspection tour of Navy and Marine Corps dental activities, using various kinds of regularly scheduled Armed Forces aircraft including helicopters and sea planes. Some of the

Map of 37-day global flight made by Rear Admiral A. W. Chandler, D.C., U.S.N. between August 29 and October 4, 1951.

planes were so-called "plush jobs," others were the "bucket seat" type, and one was an evacuation plane with a capacity load of stretchers, 4 tiers high. The passengers aboard this plane were required to travel in a horizontal position which was quite comfortable although there was not enough space between the stretchers to raise a book so one could read.

The total distance traveled was 29,819 air miles which required 172 hours and 33 minutes flying time with a total of 102-take-offs and landings under varying weather conditions. The longest hop was 13 hours and 35 minutes from the Naval Air Station in Alameda, California, to the Naval Base at Honolulu aboard the Navy's giant transport seaplane "Mars." Our shortest flight was 15 minutes in Korea aboard a Marine Corps mosquito helicopter from the top of one of the numerous Korean hills. This happened to be the Marines' furthest outpost while they were engaged in an offensive about 30 miles north of the 38th Parallel.

Inspects Hospital Ship

I had the opportunity of spending several days in Korea where I inspected the dental department aboard the naval hospital ship USS Repose and the dental facilities with the First Division of the Marine Corps. I remained two nights aboard the hospital ship which was located close by Pusan, a crowded city at the southern tip of the Korean peninsula.

I visited many patients in several of the wards and observed the capable personnel of the Medical Department of the Navy working day and night providing the best possible care for the Korean war casualties. In providing adequate medical and dental care, no treatment was too costly, and race, creed, rank, or branch of service was not considered. There were two dental officers and four technicians aboard to take care of the dental needs and a complete dental service was provided. This included specialized service in oral surgery, prosthodontia, and maxillofacial prosthesis. Whenever the ship reached its maximum patient load, it was relieved by another Navy hospital ship while it transported its patients to the large U.S. Naval Hospital in Yokosuka, Japan. I visited this hospital upon my return from Korea and was impressed with the excellence of all phases of this command.

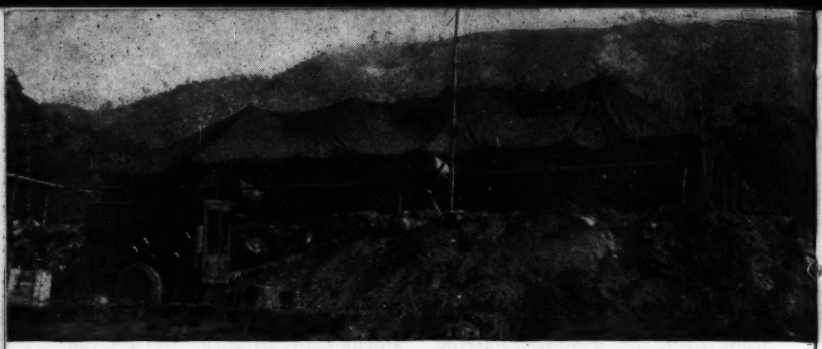
About an hour and a half by air from Pusan, we visited the Eighth Army headquarters near the perimeter of the devastated city of Seoul north of the Han River. Here we secured further air transportation and, in 31 minutes, landed at Injie, a Marine Corps airfield near the 38th Parallel where I was greeted cordially by the commanding general of the First Marine Division, Major General G. C. Thomas, a hero of Guadalcanal, and the di-

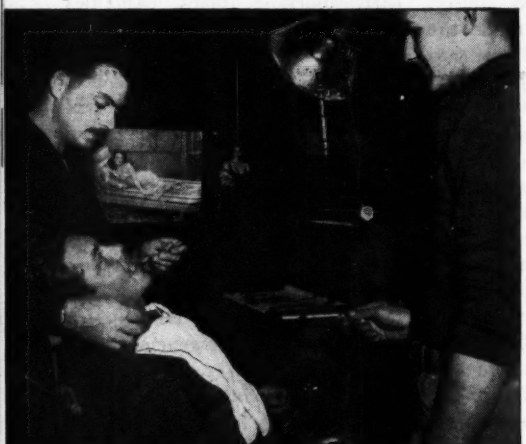
vision dental officer, Captain F. C. Snyder (DC) USN. Here I transferred to a two-passenger Marine helicopter and in 15 minutes we landed in a small 25-foot clearing close by the First Marine Division headquarters. The rest of my party traveled to the headquarters by jeeps over the winding, narrow, bumpy, hilly, congested, dusty, treacherous roads and made the strenuous trip in a little over two hours. The commanding general was a most gracious host and provided me with a comfortable sleeping bag located in a small truck next to his headquarters and invited me to eat in his mess tent.

Dentists Assist Casualties

The Marines were busily engaged in taking another "hill" from the enemy north of the 38th and my arrival was timely in that I was able to see all units of the division in action. During this offensive, the division dental officer and I, accompanied by several other dental officers, visited the last outpost and forward areas where live ammunition was going over our heads toward the enemy where we could see the great explosions of the shells. Incidentally, I was pleased to hear Colonel Herman Nickerson, Jr., USMC, officer in command of this outpost, speak with high praise of the assistance and effectiveness of the great fire power of our naval ships in the bombardment of enemy-held coastal and inland hills and fortifications. One day, about 2 A.M., after hours of continuous shelling, I noticed the General proceeding to the front lines to direct the capture of the hill previously shelled. The Commies were dug in those hills like moles and many survived the shelling and were waiting for our Marines to advance. During the early morning, many casualties were rapidly admitted directly from the battle line to the forward medical battalion tent. Dental personnel aided the medical officer in administering initial injections, treating shock with whole blood and blood plasma, cleaning, closing, and redressing battle wounds, and as anesthetists. A division surgeon recently wrote to the Surgeon General as follows: "The battalion dental officer has been invaluable during the recent engagement. He rendered surgical repair in over 100 such cases in addition to performing many tracheotomies and nerve blocks. He has been recommended for the Bronze Star."

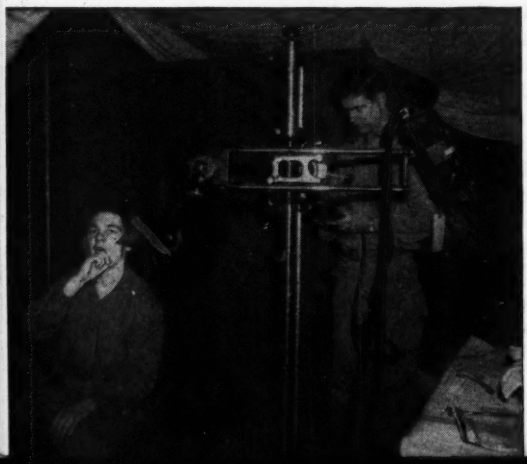
In the afternoon of that day, after looking over the captured prisoners of war, the division dental officer and I inspected two rear area dental clinics about 45 minutes away by helicopter. On our return trip, we were within 5 minutes of headquarters when we encountered a severe wind and rain storm and the "kopter" began swaying back and forth violently in the dark narrow valley between the mountain ridges. The pilot indicated that he could not



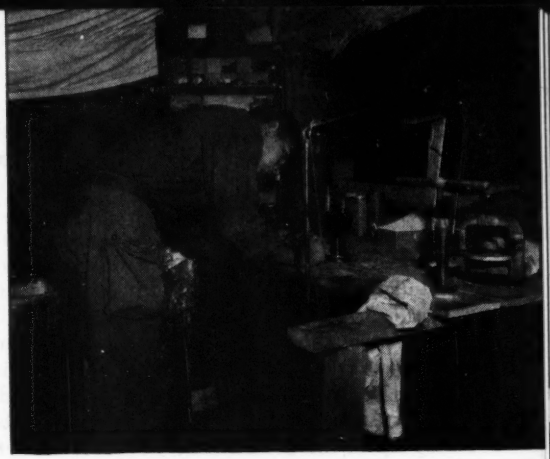


The "flying circus," the First Marine Division dental clinic shown ready for operation in Mago-ri, North Korea. This mobile clinic provides complete dental care for troops in the forward areas.

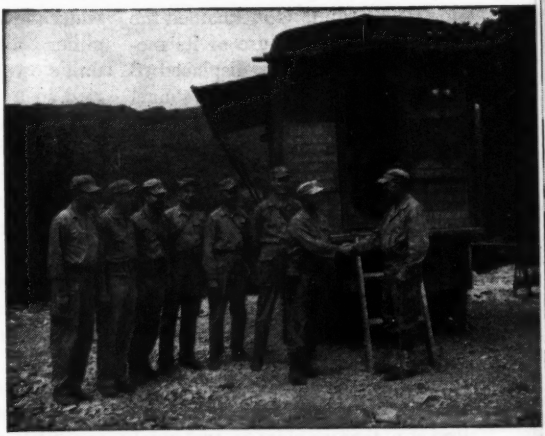
An interior view of the mobile dental clinic with the Marines at Pyongchon, North Korea. Shown treating a serviceman-patient is Lieutenant (jg) Jerome J. Beaudry, (DC) USNR (left), assisted by Kenneth M. Bubnick, (DN) USN.



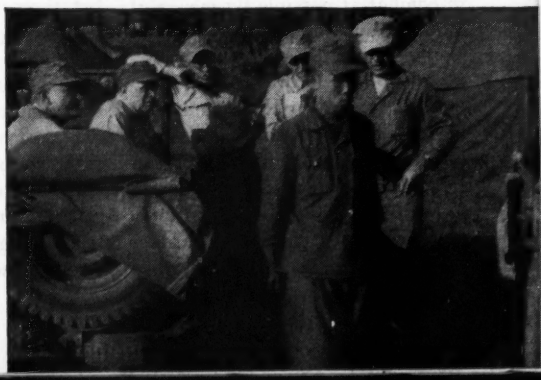
Dental X-ray equipment being operated by Allen C. Haushalter, (DN) USNR, X-ray technician. The darkroom is in the background.



In the dental prosthetic repair unit, Raymond J. Girgash, (DT3) USN, prepares a restoration.



A new mobile dental unit to be used by the "leathernecks," a converted field kitchen truck, is dedicated to Thomas A. Christensen, Jr., first dental technician killed in Korea. At the dedication ceremony Captain Francis C. Snyder, dental officer of the First Marine Division who originated the idea of the unit, shakes hands with Major General Gerald C. Thomas, Commanding General of the Division.



Captain Clay A. Boland, (DC) USN, and Admiral Chandler (left to right in jeep) look over one of the prisoners of war captured during a morning offensive.

make it. I concurred and immediately he about-faced and returned in the direction of the wind and rain to the dental clinic we had just inspected. Luckily, we made a safe landing here. We transferred then to an enclosed ambulance and returned to headquarters on the dark, slippery, narrow, muddy, mountain road, a 2½-hour trip.

The next day we witnessed the moving to a forward area and the setting up of the dental clinic we inspected the day before. This division dental clinic is nicknamed the "flying circus" because of its mobility, having been displaced 8 times in 4 months. Its personnel includes 8 dental officers and 5 dental technicians. The equipment consists of a 3-section hospital tent (20′ x 50′), 10 dental field operating units, X-ray unit, dark room, emergency dental prosthetic repair unit, 9.4 kw generator trailer, and a ¾-ton truck and water trailer. Complete dental service is provided for Navy and Marine Corps personnel in Korea. Preventive and restorative operative dental services are taken as close to personnel in combat as possible by means of mobile dental facilities.

Mobile Dental Unit

The Marines in Korea may not have "all the comforts of home" but they have something few statesiders have—a dentist who comes to see them. A mobile dental unit, manned by a dental officer, a dental technician, and a driver, is making patient-to-patient calls now among Marine troops near the front. As a result of his actual field experience, this unit was conceived by Captain F. C. Snyder, division dental officer of the U.S. Fleet Marine Forces in Korea, and was built there by the Marines' engineer batallion from standard available material and equipment. They converted a 6x6 field kitchen truck into an acceptable "dental clinic." It is wired for electricity and fitted with a tank to provide running water. Electricity can be supplied either by outside sources or by the unit's own generator which is carried in a ¼-ton trailer. This outfit is unique in that it is self-powered. Therefore, a tractor or truck for hauling is not necessary. It can be moved as far forward as may be permissible, independently and quickly. At an appropriate ceremony it was dedicated by the commanding general to Thomas A. Christensen, Jr., the first dental technician killed in Korea. Both dental officers and enlisted men have performed gallantly in action against the enemy. In actual combat, their primary duties have been ministering to the care of the wounded. In many instances this is performed under fire, and it was this that caused the death of the dental technician. His action while exposed to enemy fire was an inspiration to all who observed him. Christensen's display of outstanding courage and devotion to duty was in keeping with the highest

tradition of the United States naval service. For his gallantry in action he was awarded the Navy Cross (posthumously).

A naval reserve dental officer, Lieutenant (jg) Morton I. Silver, was awarded the Silver Star Medal for the heroism he displayed in administering to the wounded under heavy fire with the Marine Infantry Regiment in Korea. Lieutenant Silver risked his life repeatedly to assist regimental casualties.

The following numbers and types of decorations have been awarded naval dental personnel during the Korean war to February 1, 1952:

Navy Cross (posthumously)
1 dental technician

Silver Star Medal
1 dental officer
1 dental technician

Bronze Star Medal with Combat "V"
6 dental officers
1 dental technician

Bronze Star Medal with Combat "V" (Army)
1 dental officer

Letter of Commendation with Combat "V"
7 dental officers
6 dental technicians

Presidential Unit Citation
22 dental officers
16 dental technicians

Although there is a shortage of dental officers in the Navy at the present time, we have no trouble filling our Korean and overseas billets, volunteers for this type of duty are so numerous. However, due to the hazards of this assignment, a rotation plan is in effect whereby dental officers and dental technicians who serve for 9 months in Korea are relieved and returned to the United States for duty within one year of their departure from the States. No doubt this rotation plan has something to do with the high morale noted among the dental personnel stationed in Korea. It was gratifying to hear the commanding general of the First Marine Division (as did all the commanding officers of the naval establishments visited) speak with high praise of the efficient medical and dental service.

My return to the United States was filled with incidents, but I am sure the memories of my Korean inspection tour will be the most lasting. The dental profession can be proud of the actions of its individual members who are serving their country in the Armed Forces.

Bureau of Medicine and Surgery
Washington 25, D.C.

EDITOR'S NOTE: The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

Those Secret Messages

BY C. B. WARNER, D.D.S.

BY SECRET messages I refer to military ciphers, cryptograms, codes, and puzzle crypts. There are some differences between these systems and I use them as a hobby. Are they mysterious? Are they exciting? Extremely so. Are they useful? As a result of the competition between nations for an impregnable military cipher, we might surmise—if war should come—that such a code could be our most valuable asset! Cryptography provides a fascinating off-time activity and it has a growing appeal for almost anyone who tries it. For this reason, and the fact that it is so necessary and urgent to the defense of our country, I cannot urge dentists strongly enough to investigate this engrossing hobby.

Its importance is emphasized by a long illustrated article in *Collier's* of October 28, 1950, which relates how all military operations were held up at Colmar, France, because a truck containing cipher material was stolen. The general staff would rather have suffered the loss of a thousand other trucks. Troops were detailed over the area, and it was recovered without damage. We broke the Japanese Code and used it to win the naval battle of Midway. The Russians discovered the German Code, which enabled the British to trap seven German battleships.

Decoding of ciphers is more than a recreation for dentists; it provides invaluable international military information.

This article also gives much attention to the one large civilian group devoted to research in the science of cryptography. High praise is given to The American Cryptogram Association of Canton, Ohio, for its activities in our last great war. This organization started in my home with a group of seven and now has members all over the world. Its official organ, *The Cryptogram*, was published first in Biloxi, Mississippi, as a small two-sheet affair. Now it contains scientific articles and publishes hundreds of ciphers for its readers to solve. These range from easy puzzles, which anyone can solve, to various types of military crypts, many of them in seven different languages.

Hobby Serves Government

The attack on Pearl Harbor came so suddenly that our government had need of help in every direction. Since many of the finest cipher experts in the world were in our organization, we were able to aid in this highly specialized science and won commendation from President Truman. Our members were often called to Washington for government service and are still being summoned. Within the last months we have thus lost our editor, our national treasurer, and the chairman of one of our important committees for cipher work in the Army.

The American Cryptogram Association also serves as a sort of ground school for education in this field. The beginner is attracted to the cryptogram, the aristocrat of puzzles, by its weird fascination. If you have been thrilled by contract bridge, you can safely multiply its enchantment by ten when you get in this corner. One of our experts, Rosario Candela, has this to say, "It is a subtle, incurable, all-pervading malady. The moment it grips you, it spreads its tentacles rapidly to the most recondite corners of your nervous system, and stays there never to leave you. It gives each victim delusions of grandeur. It makes him a sad nuisance to his family and his friends." Candela should know. Recently he solved a French cipher which was written forty years ago and was considered unbreakable. For three months he chipped at it and the report of how he did it fills 137 pages.

Like other semi-military organizations, such as the Red Cross, CARE, and The Crusade for Freedom, we are always on the alert. Sometimes we find a real cipher genius and there is great rejoicing, for our government is in desperate need of such skill. Often I am asked how to make a start in cryptography. If you have a friend with

experience in this field, that is your best bet. Some go to the public library. Others write to the American Cryptogram Association. Many hunt for crypts in their Sunday newspapers. You may not get the thrill at first, but as you proceed—well, it comes for keeps.

It is not my intention to overpaint the picture. A few years ago I attended our fourteenth annual convention at the Hotel New Yorker. At the banquet I sat next to one of our experts and said, "You were helping in Washington —did you have a good time?" "Well," he replied, "they paid me twelve thousand dollars a year, but they would let no one in to see me. A visitor would have to pass three secretaries. I served three years and when I came out I weighed seventeen pounds less than when I started."

As a recreation, the crypt fan has advantage over the card player. He does not need a crowd; can start and stop when he pleases.

Biloxi Community Club
Biloxi, Mississippi

DENTAL CARIES VS. CLIMATE

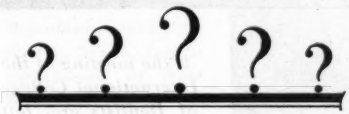
ACCORDING TO the facts collected and analyzed by Clarence A. Mills, Ph.D., M.D., in his book MEDICAL CLIMATOLOGY,[1] geographic and climatic conditions are the greatest determinants of dental caries. There is evidence, he reports, of a total lack of caries in tropical countries and a steady and undeviating increase of the disease the further into the cooler regions one goes.

Other geographic features of environment have a bearing on dental health also. A Public Health Survey analyzed data pertaining to the source of water, its average hardness, and the caries rate (per 100) of children drinking the domestic supplies of 75 different cities. This produced figures illustrating the drop in rate of caries as water becomes harder. Since additional statistics showed the mean latitude of these cities to be virtually the same, the survey proves that the softer water of rivers and lakes is responsible for a 30 per cent higher caries rate than is produced by the harder water of wells and springs.

Although hardness of water and upland locations do affect the caries rate, Doctor Mills believes that latitude and consequent climatic differences overshadow these factors. Even in high caries-rate northern states the incidence of dental caries is three times less during the summer than it is during autumn-winter months, while the months from winter to spring increase this rate to five times what it is during the summer.—*Prevention, November* 1951.

[1]Mills, C. A.: Medical Climatology, Springfield, Illinois, Charles C Thomas, 1939.

So You Know Something About DENTISTRY!



QUIZ XCII

1. The superior cavity (the meniscotemporal) of the temporomandibular joint is (a) larger than, (b) smaller than, (c) the same as, the inferior cavity.

2. Does an increase in palladium in a gold alloy increase or decrease the resistance to tarnish?

3. Should the pulp of a deciduous tooth be capped when (a) early root resorption has occurred, (b) normal sensitivity of the pulp is in doubt, (c) the pulp tissue is not a light pink color?

4. What is recession?

5. In a completely edentulous person with a class III occlusion, the teeth are usually most efficient with (a) an edge-to-edge bite, (b) upper anteriors slightly inside the lowers, (c) upper anteriors slightly outside the lowers.

6. As the mandible shifts downward and forward during growth, how do the maxillary and mandibular teeth maintain contact?

7. Multiple mixes of amalgam should be used if the condensing requires more than (a) 6, (b) 1, (c) 3, minutes.

8. True or false? Areas of sclerotic bone are commonly mistaken for root fragments in the roentgenogram.

9. Which is the most convenient and accurate method for curing denture base resins? (a) water vapor, (b) dry heat, (c) induction, (d) water bath.

10. Is long-standing allergy related to the incidence of malocclusion?

FOR CORRECT ANSWERS SEE PAGE 746

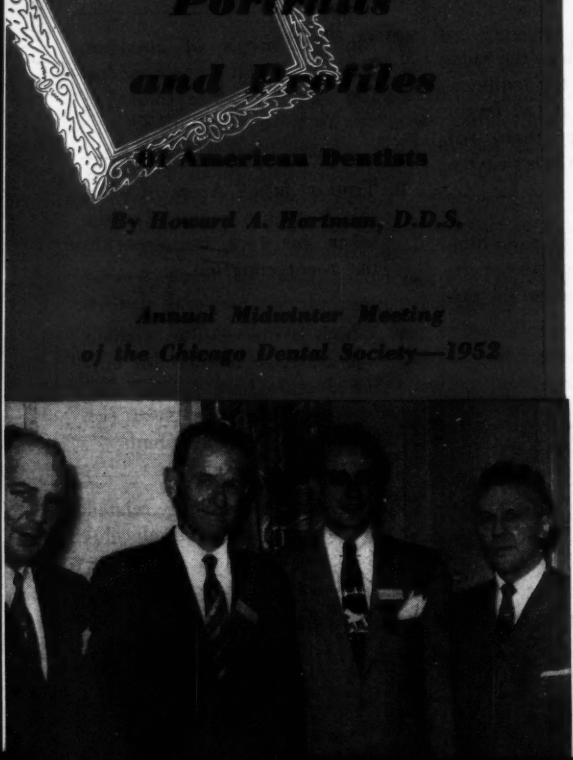
Portraits and Profiles

of American Dentists

By Howard A. Hartman, D.D.S.

Annual Midwinter Meeting of the Chicago Dental Society—1952

At the meeting of the International College of Dentists are, left to right: J. Wesley Lucas and Clyde E. Tuttle of Wichita, Kansas; Charles W. Carrick, Oberlin, O.; Paul J. Aufderheide, Cleveland; and Captain Everett K. Patton (DC) USN, Parris Island, South Carolina.



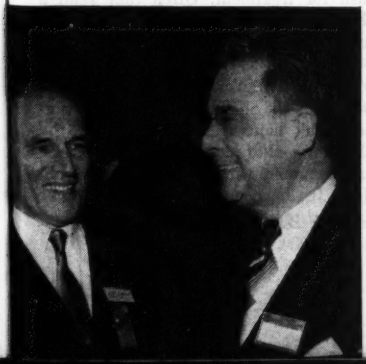
Left to right: W. Harry Archer, Pittsburgh, Pennsylvania; Frederick J. Wolfe, New Orleans; Emil H. Bollwerk, St. Louis; and Victor L. Steffel, Columbus, O.

Right: Harold H. Hayes of Chicago, General Chairman of the 1952 meeting, (left) with Senator Harry F. Byrd of Virginia, speaker at first general session.

Below right: Warren S. Tucker, Frank J. Houghton, and Alfred E. Smith (left to right)—all of New Orleans.

Bottom right: David J. Fitzgibbon of Washington, D.C., President of the International College of Dentists (right), installs Fred A. Richmond of Kansas City, Kansas, as President-elect.

Below: Lloyd H. Dodd of Decatur, Illinois, (right) congratulates James H. Keith of Evanston, Illinois, new President of the Chicago Dental Society.



Dentists in the NEWS

Van Wert (Ohio) Times-Bulletin: Major Robert H. Frey, Van Wert dentist, is now serving as base dental surgeon in charge of the dental clinic of the Seventh Tactical Air Control Squadron in Korea. Members of this unusual air outfit fly small unarmed planes, constantly on the lookout for enemy targets. When one of these "mosquito" pilots sights an enemy tank or truck, he guides a fighter-bomber to the target and it is destroyed. This tactical squadron has received a presidential citation for its work in Korea. Besides Major Frey, there are two other dentists, three flight surgeons, and forty corpsmen in the medical department.

Newark (New Jersey) News: Doctor Philip Nemoff, 64-year-old Newton, New Jersey, dentist, with two old friends, Chester J. Pegg, 70, and Alexander J. Lackner, 76, have a solution to one of the problems born of inflation. They are planning a machine shop where they intend to manufacture a new type of paper milk container developed by Lackner. The unique feature of this enterprise is the fact that only people over 60 will be employed in the shop to "help older folks who can't get jobs."

Seeking funds to use in the expansion of Pegg's Newton machine shop, the three drove to New York to appear on TV's "Strike it Rich" program and won $500, an important step in the growth of their miracle machine shop to help old hands become young.

Richmond (Virginia) Times-Dispatch: "Imagine a clown being pretty," jokes Doctor Lynwood C. Holland, Suffolk, Virginia, dentist. But, as ridiculous as it sounds, it is true; children who see the 68-year-old hobby clown perform with the circus really like his storybook appearance. Whenever a circus comes within 200 miles of Suffolk, the doors of his office close and Doctor Holland becomes a clown. With his pet duck, "Pink Lemonade," he has all sorts of acts that tickle the youngsters. One of his newest is the Big Fat Dutchman. Through a mechanical device which he created, Doctor Holland can inflate himself to a circumference of thirty feet and then collapse to normal size. The Suffolk dentist is happiest when he gets into the orange wig, white gloves, polka-dotted pants, and oversized lips. "I make the children happy," he says, "and they think I'm pretty."

Los Angeles (California) Times: Trust territory dentist of Guam, Doctor John Kelly, really has to win his patients by performance. When he sets up his chair on his visits, the natives keep their distance until a brave one, driven by toothache, approaches. When they see their friend is still alive, unharmed, and seemingly out of pain after an extraction or restoration, the natives all rush for treatment. Often they send a child for treatment first. If he does not scream, Doctor Kelly has a busy day.

Greensboro (North Carolina) Record: Doctor Neal Sheffield, Greensboro horticultural hobbyist, has achieved the ultimate goal of most amateur gardeners. Last summer, with the help of his son, Neal, Jr., he completed a 12 by 14-foot English type greenhouse, an all-glass

structure built on a cinder block foundation. Doctor Sheffield's interest in gardening is an offshoot of his victory gardening during World War II, when he raised vegetables and bright outdoor flowers. Now he has winter-blooming snapdragons, carnations, and azaleas. In addition to his forced blooms, the Greensboro dentist has begonias, geraniums, and a variety of other flower cuttings given to him by neighbors to "stick down" in the sand.

Columbus (Ohio) Dispatch: Members of the Columbus Dental Society gathered at a dinner party recently to pay tribute to Doctor Harvey V. Cottrell who, at the age of 84, still maintains a daily schedule in his dental office. Doctor Cottrell has practiced steadily since his graduation from Ohio State University in 1900 and, in addition, taught in the dental school at the University for thirty-three years. He was retired as professor emeritus of prosthetic dentistry in 1939. The veteran Columbus dentist is a charter member of the Columbus society and was fourth president of the American Denture Society.

New York (New York) Times: The only woman in the freshman class at Tufts College Dental School, Mrs. Elihu Silverman, was commended recently for her work in histology. Doctor Anna Quincy Churchill, professor of anatomy at Tufts, said Mrs. Silverman turned in "the best original paper in histology that I have seen in more than twenty-five years."

Cleveland (Ohio) Plain Dealer: Prior to his recent retirement, if Doctor Bernard H. Cooper had no patients in his Cleveland dental office, he probably could be found in a little back room pawing through an assortment of bolts, gears, knobs, and screws littering shelves on three sides of the room. This dentist is a "sculptor of parts." He fashions imaginative pieces from various combinations of discarded parts; a finished statue might consist of a section of a rear axel, some worm gears, and a wheel. Doctor Cooper has exhibited his work in the Cleveland Museum of Art May Show for the last ten years. Recently he showed his salvage sculpture in the Los Angeles Museum of Art.

Council Bluffs (Iowa) Nonpareil: Commander Kenneth L. Longeway, USN, formerly of Council Bluffs, has been named president of the Panama Canal Zone Dental Society, the first time in twenty years that the post has been given to a Navy dentist. A 15th Naval District dental officer, he has been in the Canal Zone for a year.

Jacksonville (Florida) Journal: Lieutenant Robert W. Davis (DC) USNR, has been awarded the Bronze Star Medal and Temporary Citation "for heroic achievement in connection with operations against the enemy" in Korea. The former Norwood, Massachusetts, dentist was serving with the Fifth Marine Infantry Regiment of the First Marine Division in the vicinity of Yanggu, North Korea, where he displayed exceptional courage under heavy artillery fire on May 29, 1951. The citation states that Lieutenant Davis moved into the shelled area with complete disregard for personal safety and administered first aid and assisted the wounded to refuge.

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

Ruth E. Renkel, P.O. Box 695, Elyria, Ohio.

Mrs. E. A. Troxler, 500 Hillside Drive, Greensboro, North Carolina.

(*Continued on next page*)

Harriett Shipley, Route 3, Council Bluffs, Iowa.
Mrs. Charles K. Perkins, Louisa, Virginia.
Fred F. Tomblin, 2523 — 55th Street Huntington Park, California.
Abraham Haber, D.D.S., 1780 — 75th Street, Brooklyn 14, New York.
Mrs. Roy Jones, Pataskala, Ohio.
Mrs. W. D. McCracken, Route 1, Middle Point, Ohio.
Philip Nemoff, D.D.S., 109 Spring Street, Newton, New Jersey.
Mrs. J. B. Smith, 557 Chelsea Avenue, Jacksonville, Florida.

CAN YOU USE A DOLLAR?

To EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

DON'T MAKE THE SAME MISTAKE—ONCE

(*Continued from page* 704)

or an accident of equal improbability that has happened to him. We are all human beings as well as dentists and, as such, we will make errors and use poor judgment occasionally.

Therefore, we may expect such outlandish situations to continue; but that they can be reduced to the minimum. The answer, of course, lies in the maintenance of continual care and vigilance, not only against the accidents which we have been taught to expect, but against every conceivable, and even inconceivable, eventuality.

Reminiscence over your latest golf score or yesterday's big contract, while you operate, is one sure way to put yourself right in the middle of one of the situations described here. Just think about the patient you are treating; there is more than enough there to occupy even the most agile mind.

7 West 96th Street
New York 25, New York

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

TECHNIQUE of the Month

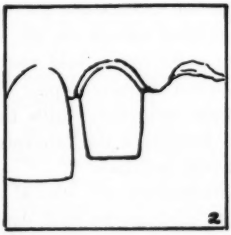
Conducted by W. EARLE CRAIG, D.D.S.

Drawings by Dorothy Sterling

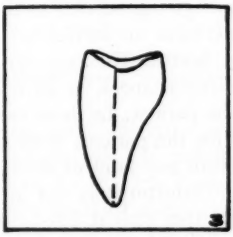
Anterior Abutment for Bridge

By RAYMOND K. HYDE, D.D.S.

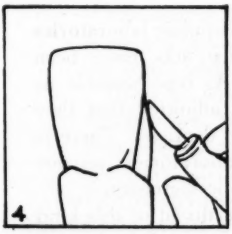
The case: upper left central and lateral incisor missing. Abutments on right central and left cuspid.



Prepare the central and make a porcelain jacket crown.



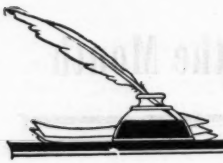
Fit the crown on the preparation. Using a disk, cut the crown in half.



Fit anterior part of crown on lubricated die. Using inlay wax carve up the lingual half of the crown. Remove and cast in gold.

Place lingual casting on the right central. Place the cuspid abutment in position. Make bridge supplying the missing teeth.

After bridge is cemented in place, cement the anterior porcelain half of jacket crown to the central over the gold casting.



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

WHY GO TO A DENTIST FOR A DENTURE?

IF THERE is any high indignation in dental circles over the laboratories that are practicing dentistry, little of this feeling has found expression in dental publications. Dental societies, with an occasional exception, do not seem to be concerned with the type of competition that is draining practice from the offices of dentists. The ethical dental laboratories that are giving service to the dental profession are scrupulously careful to perform no service for a patient except on the written prescription of a dentist. The only service a dentist should request, even under these circumstances, is an occasional denture repair for the convenience of the patient. In these cases the laboratory bills the dentist who in turn bills the patient. With this safeguard the laboratory is protecting itself from any taint of direct dental practice.

Unfortunately not all laboratories are ethical any more than are all dentists ethical. Fly-by-night laboratories that cater directly to the public have been established in most large cities. Their advertising appears in newspapers and magazines. Although the advertising rates may be too high for these laboratories to use the large metropolitan papers, they find an extensive and gullible audience among the readers of neighborhood, foreign language, and church papers.

It is ironic, or maybe it isn't, that these direct-to-the-public laboratories have sprung up since many state dental practice acts have been amended to do away with the advertising dentist. As reprehensible as many advertising dental quacks were, it must be admitted that they at least were compelled to have a license to practice dentistry. There is no such requirement or safeguard necessary for laboratories: anyone can set himself up in business as a direct-to-the-public merchant.

One of the dental organizations that has taken the threat of this kind of dental laboratories seriously is the College of Dental Surgeons of British Columbia. In a large paid advertising space in the *Victoria (B.C.) Daily Colonist*, this dental organization has said under the heading "Why Go to a Dentist for a Denture?":

Only a dentist can determine whether your teeth should be extracted or saved. His first aim is always to save, rather than extract. But when your own teeth must be exchanged for dentures, you should see your dentist and nobody else.

The inside of your mouth is like your face, a highly individual thing, and requires a considerable knowledge of anatomy, physiology, and diseases of the mouth. There are unexpected dangers ahead if you let an unqualified person fit a plate at so-called "bargain prices."

Consider these facts:

6% of all cancers are found in the mouth; 3% of all cancer deaths can be traced to the mouth.*

An incorrectly fitted plate can cause deafness or neuralgia.

Without a dentist's knowledge, could you be sure that a plate was not fitted over a diseased pocket, a rotting tooth stump, a cyst, or whether the plate was going to aggravate or cause a diseased condition?

Faulty dentures can foster stomach disorders, even malnutrition, through badly chewed foods.

Your dentist is specially trained to detect any indication of chronic irritation that may lead to malignant growth. He makes sure of healthy bone tissue by X-ray, checks for hidden roots, cysts, remnants of abscessed teeth. Along with his skills and techniques, which have taken your dentist years to acquire, he must invest a large sum of money in equipping his own operating quarters.

Remember, the law allows only a qualified dentist to work on your mouth. This is for your protection.

The dentist is trained to operate in the mouth. The technician is trained to construct, out of the mouth, artificial substitutes for lost teeth, under the careful direction of the dentist.

However, when the public goes to a man who is not a dentist for dental work, the law—framed for public protection—is being broken and a risk is being run that can lead to suffering and unnecessary bills later on.

This direct and vigorous statement by the dentists of British Columbia should be a model for other dental groups that are concerned with the inroads being made by dental laboratories against the public health and dental practice.

Edward J. Ryan

*American Cancer Society, 1946 Official Publication.

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Diet

Q.—I am enclosing a list of one week's food intake of a young woman, 16 years of age, who weighs 115 pounds and is about 5 feet 7 inches tall. Her general health is fair, blood and urine negative, skin sallow and a bit oily, but her general outlook mentally is keen and good.

Can you suggest anything after studying her diet? At this point, I am at a loss for any further adjunct to my local treatment.—M.H., New York.

A.—You do not say in your letter just what your problem is in the case of the 16-year-old girl whose dietary for a week you have enclosed with your letter. If the problem is one of caries, the diet is well restricted in carbohydrates. If the problem is one of periodontal trouble, the young patient should have much more vitamin C food. Of course, she should have more vitamin C anyway. Her diet is quite well balanced generally.—GEORGE R. WARNER.

Adjustment to Dentures

Q.—The full upper and lower dentures I made for a woman seem satisfactory in every respect with one exception. When she chews, the food collects in the mucobuccal fold instead of staying within the lingual confines of the dentures. The occlusal plane of the lower denture is below the dorsum of the tongue, which is as it should be, I thought. To me, it does not appear too low. Yet, what else could be wrong? If I have to raise the occlusal plane of the lowers, what is the best procedure? —A.S., New York.

A.—This woman's present dentures are probably made narrower or flatter on the buccal surfaces so that they do not fit the cheeks as her former dentures did. In all probability, if she will persist in wearing these dentures for a few months, the cheeks will adapt themselves to the dentures and exclude the food as they should.—V. CLYDE SMEDLEY.

Gingivitis

Q.—A physician friend of mine recommended a patient who presented with mouth soreness. She complained of soreness and sensitivity of the lips and muscles upon movement. The color of the gingivae in the anterior is a vivid red with some blotching. The teeth are not tender nor is there any looseness. This condition of the gingivae has been present for about five years. She has taken drugs for asthma for about fifteen years.

The patient was born in Germany but came to this country at the age of one year. She is a school teacher about fifty years of age.

It seems the upper anterior area is the more tender. However, she has no tendency to bleed in any area, even on finger pressure. Do you think the asthmatic drugs could cause the difficulty or

would it be systemic?—M.C.S., Illinois.

A.—The condition of your patient's gingivae does not seem to be that of an ordinary hypertrophic gingivitis, but rather one of systemic origin. Hay fever sufferers sometimes have a gingivitis during the season of pollenization.[1] This may indicate that this asthmatic is allergic to the medication she is receiving. Some patients are allergic to certain dentifrices with a resulting inflammation of the mucous membranes and gingivae. It would seem wise in your case to explore thoroughly the possibility of the gingivitis being due to an allergic reaction.—GEORGE R. WARNER.

Exposed Dentine

Q.—With regard to your answer to C.H.C., Iowa, in ORAL HYGIENE,[2] I should like to know how to prepare the sodium fluoride paste you mention using in the treatment of sensitiveness of exposed dentine.

I have purchased a 4 per cent aqueous solution of sodium fluoride, but have been unable to have a pharmacist compound the paste. Your prescription for this would be much appreciated.—S.P., New York.

A.—The sodium fluoride paste of Hoyt and Bibby[3] consists of one part sodium fluoride, one part glycerine, and one part white clay. The above authors advise first wiping the sensitive area with a 4 per cent solution of sodium fluoride. Then, with the tooth protected from mouth moisture, the paste is to be rubbed in with a plastic instrument until the sensitiveness disappears. I have found it more comfortable and more effective to cover the sensitive area with the paste for from three to five minutes without rubbing it. The rubbing then usually requires only one or two minutes before the sensitiveness disappears.—GEORGE R. WARNER.

[1]Miller, S. C.: Textbook of Periodontia, Philadelphia, The Blakiston Company, 1950.
[2]Sensitiveness, ASK ORAL HYGIENE, ORAL HYGIENE **41**:1438 (October) 1951.
[3]Hoyt, W. H., and Bibby, B. G.: Sodium Fluoride for Desensitizing Dentin, JADA **30**:1372-1376 (September 1) 1943.

Infected Deciduous Molars

Q.—I have a patient, an 8-year-old girl, who has several excessively carious deciduous molars with fistulas. The tissues around these teeth swell about every six weeks until the fistula opens. Her former dentist has advised that these teeth be left in, regardless of their condition, until time for permanent dentition. My contention is that these teeth should be removed.—H. W., South Carolina.

A.—We agree with you wholeheartedly that infected deciduous teeth should be removed. These young patients are most susceptible to serious results of focal infection. In some cases, following the early removal of deciduous molars, it is necessary to use space maintainers to prevent malocclusion.—GEORGE R. WARNER.

Rampant Caries

Q.—We realize the enclosed roentgenograms are not good, but between an uncooperative, gagging patient and a poor supply of film we feel fortunate that they show anything. What we wish to show is the large number of restorations present and the number of carious areas.

The patient, a 16-year-old boy, apparently in good health, came to our office in March, 1949, for examination. We were almost shocked by the number of restorations present, and still we found thirty carious areas. We immediately referred him to a physician for a complete checkup. The report came back—no abnormalities.

We placed him on a sugar-free diet and restricted the carbohydrate intake to an absolute minimum. We recommended a high protein and vitamin intake, plus an ammoniated dentifrice, and mouth rinses. Sodium fluoride treatments were given, the teeth restored, and the alloys polished. The restorations were completed in September 1949.

In September 1950, he returned to our office and we placed eight new restorations. There were areas of decalcification, so we used Gottlieb's impregnation method for possible retarding of the process. In April 1951, he returned again. Nearly every exposed surface of the teeth was decalcified in small areas. We cleaned out some of the caries in the mandibular teeth and placed black copper cement for temporary protection.

I am at a loss as to what I should try next. I feel that it is hardly economically sound to continue restorations under these circumstances and yet I hesitate recommending full mouth extractions. Please advise me as to what course, if any, I might follow. These cases of rampant caries are beyond my scope.—J.C.C., Kansas.

A.—You have handled the case of rampant caries in your 16-year-old boy wonderfully well and yet the results of your treatment are most discouraging.

I notice that you did not see him from September 1949 until September 1950. I feel that such a case should be seen at least four times a year when a prophylaxis treatment should be given followed by a sodium fluoride treatment. At each visit one can check on the home care and diet, and decalcified areas in the posterior teeth can be treated with silver nitrate. Sodium fluoride is of no value after decalcification has taken place.

It would seem to me to be worth while to keep up the fight to save this boy's teeth for at least a few years. In similar cases we have been gratified by the incidence of caries decreasing at about 20 years of age and an apparently hopeless case becoming manageable.

The reports on the use of the ammoniated dentifrices indicate that they are helpful in reducing the incidence of caries if they are used within an hour after each meal.[4] The teeth should, of course be brushed thoroughly so that the dentifrice will be carried into usually inaccessible areas.—GEORGE R. WARNER.

Salivation

Q.—A patient of mine seems to have an excessive flow of saliva. He wears dentures but he had this saliva difficulty before he started to wear them. Could you suggest some remedy for this?—J.W.M., New York.

A.—An excessive flow of saliva can be endured, if not cured, psy-

[4]Kesel, R. G.: An Evaluation of Recent Developments in Caries Control, Oral Surgery, Oral Medicine and Oral Pathology **4**:439-448 (April) 1951.

WERNET DENTAL LORE

MAY 1952

While the number of dentists in practice increases each year, statistics indicate it fails to keep pace proportionately with the increase in population. During the three years, 1949-1952, the population is increasing 5.31%. The number of practicing dentists however is going up only 3.99% in the same period.

* * *

Most dentists have their preferences in the matter of dentifrices; but modern practitioners seem to lack the imagination of Guy de Chauliac of the Middle Ages, who specified a formula including cuttle bone, small white sea shells, pumice stone, burnt stag's horn, nitre, alum, rock salt, burnt roots of iris, aristochlia and reeds.

* * *

No single nation can take full credit for the perfecting of mineral (porcelain) teeth. Between 1810 and 1840, dentists in France, England and the United States made noteworthy contributions to this new development, displacing the natural and carved-ivory teeth previously used for "pivot" crowns and dentures.

* * *

Oral surgery as a dental specialty was fathered in the U.S. by James E. Garretson (1828-95), who published the first text dealing with the subject.

* * *

Tapping of each huge Indian gum tree for karaya gum, the main ingredient of Wernet's Powder, is performed only every 2 to 3 years, during 8 or 9 months of the hot season, in order to obtain the highest yield and to give the tree necessary rest.

chologically. By a determined effort, one can discipline one's self to disregard the saliva, and the very disregard for it will have the effect of lessening the flow.

If the patient is unable to exercise the necessary self-control, or does not wish to, the flow can be lessened with atropine, but this should be used only under a physician's direction.—GEORGE R. WARNER.

Delayed Eruption

Q.—As a dentist, I would probably advise a patient with the following problem to let Nature take its course, but as a father, I am prompted to write to you concerning my 4-year-old boy.

He has none of his second deciduous molars. Several months ago, roentgenograms showed them to be in position to erupt with little impingement. According to your records, what is the latest age at which these molars erupt? Is it true that too early incision for such purpose will only result in a healing of the incision causing scar tissue which would make eruption more painful and difficult?—S.M., Pennsylvania.

A.—You are quite right to be hesitant about attempting to hasten the eruption of your 4-year-old boy's second deciduous molars by incising the gingiva. The result would be about what you say, simply a cicatrix.

In all probability, your boy's bone age is not in keeping with his chronologic age. This can be determined by roentgenographing the wrists. If the bone age is not normal, medical assistance will be in order, and under proper treatment probably the molars will erupt.—GEORGE R. WARNER.

Irritation Around Incisors

Q.—I have a problem which has occurred four different times in my practice.

I have a young woman patient, a college student, who spends quite a bit of her time playing the trumpet. She has played ever since she was a little girl but, for the last two or three months, she has complained of a sensitiveness in the upper two incisors. They have no restorations and must be sore from vibration or irritation due to the trumpet.

I have three other young patients who complain of the same thing and who have good teeth.

Is there anything I can advise them to do, other than to quit playing the horn, to solve this problem?—L.P.J., Kansas.

A.—I had such a patient some years ago and we solved his problem by making a stone cast of his teeth. Then we painted several coats of liquid rubber over the anterior teeth and allowed it to harden upon exposure to the air. By the next day, this flexible rubber protector or guard was hard enough to remove from the cast and place upon his teeth. He said this worked perfectly to protect his teeth from vibration. I turned the cast of his teeth and a bottle of liquid rubber over to him and showed him how to make a new protector for himself as often a he might need one.

However, I am inclined to thinl

that, with the variety of acrylics available today, probably an acrylic protective splint would be better. —V. CLYDE SMEDLEY.

Denture Refitting

Q.—I have made three sets of dentures for one patient in the last ten years. Each time she has lost vertical dimension and the lower anteriors become anterior to the uppers. She is about 48 years of age. I make a special tray for the lowers and use a gothic arch tracing. The teeth are checked for occlusion with carbon paper and stones. It seems that many of my cases are the same way, but this patient is getting tired of paying for new ones. Is there some way to prevent this condition?—C.H.B., Wisconsin.

A.—I had one patient who wore a full upper denture for fifty-five years. My father had made this denture before I was born. When I first examined it, after it had been worn forty years, this denture fit as well as any denture I ever made or saw. In fact, I am sure it fit better than it did the day it was made, for the mouth appeared to have fitted itself accurately to the denture.

I had another patient some years ago for whom I made seven denture fittings in a period of five years. And the last time I saw him they really needed remaking or refitting again. I think he, by that time, was discouraged and decided to put up with a misfit the rest of his life. At any rate, I have not seen him for a number of years. I prescribed a diet rich in minerals for this man—milk and sea kelp—but I do not think he followed it for long. He said he disliked these things and did not think they did any good.

I really do not think there is anything we can do for such a patient but prescribe bone-building foods, minimize occlusal stress as much as possible, and then rebase or remake the dentures as often as may be necessary. Always remember to provide ample free-way space and to teach patients to relax with the teeth apart at all times except when they are chewing or swallowing.—V. CLYDE SMEDLEY.

Clicking Dentures

Q.—A couple of months ago, I inserted full upper and lower acrylic dentures for a patient. Now, the patient complains of his dentures clicking or clattering and that this makes him uncomfortable.

I took a new impression of the lower, with the idea of a more secure lower denture. Then I took a new bite and closed it about 2 mm. The denture was more firm, but he still complains of the clatter. I should appreciate any suggestions for this case.—E.J.K., Nebraska.

A.—Is it possible that you still have this patient's bite open too much? Either a lack of sufficient free-way space or an unbalanced occlusion is usually the cause of clicking with dentures.—V. CLYDE SMEDLEY.

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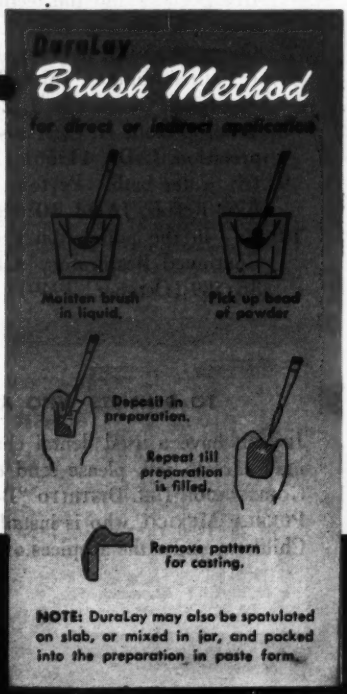

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SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ XCII

(See page 727 for questions)

1. (a) larger. (Thoma, K. H.: Oral Surgery, Vol. 2, St. Louis, C. V. Mosby Company, 1948, page 862)
2. Increase the resistance. (Lane, J. R.: A Survey of Dental Alloys, JADA **39**:427 [October] 1949)
3. No. (Grossman, L. I.: Handbook of Dental Practice, Philadelphia, J. B. Lippincott Company, 1948, page 316)
4. Detachment of the gingivae from the tooth surface. (Goldman, H. M.: Periodontia, ed. 2, St. Louis, C. V. Mosby Company, 1949, page 32)
5. (b) slightly inside. (Maloney, C. L.: Prosthetic Problems, New Zealand D. J. **45**:226 [October] 1949)
6. The alveolar processes maintain normal distance by growth at their free borders and the teeth maintain contact by continued vertical eruption. (Sicher, Harry: Oral Anatomy, St. Louis, C. V. Mosby Company, 1949, page 115)
7. (c) three minutes. (Mosteller, J. H.: Principles of Condensation of Amalgam, Georgia D. J. **24**:12 [July] 1950)
8. True. (Fixott, H. C.: Causes of Errors in Roentgenographic Interpretation, JADA **41**:561 [May] 1950)
9. (d) water bath. (Peyton, F. A.: Packing and Processing Denture Base Resins, JADA **40**:526 [May] 1950)
10. No—in the population group. (Miller, H. I.: Relation of Long-Continued Respiratory Allergy to Occlusion, Am. J. Orthodont. **35**:789 [October] 1949)

TO DENTISTS WHO ARE MEMBERS OF LIONS CLUBS

If you have a used dental chair and unit, also instruments that you may care to sell, please send complete data to Dr. Ernesto Najera, Gobernador Del Distrito "B-5," Avenida Reforma 108, Tehuacan, Puebla, Mexico, who is installing a free Dental Dispensary for School Children, under the auspices of the Lions Club of Tehuacán.

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LAFFODONTIA

"You're charged with throwing your mother-in-law out of the window. Guilty or not guilty?"

"Guilty, your honor. I did it without thinking."

"That's no excuse—you might have hit somebody on the head."

★

James: "My kid brother is only three and he can spell his name backwards."

Teacher: "Remarkable. What is his name?"

James: "Otto."

★

In a small town where two brothers are engaged in the retail coal business a religious revival was held and one of the brothers got converted. For weeks he tried to persuade his partner to join the church. One day he asked:

"Why can't you get religion and join the church like I did?"

"It's a fine thing for you to belong to the church," replied the other, "but if I join the church who'll weigh the coal?"

★

A missionary bound for a cannibal island was warned of his danger by the captain of the ship he was leaving.

Captain: "I've left three other missionaries here and they have never been heard from since."

Missionary (departing): "I'm not worrying."

A year later the captain stopped at the island. He was surprised to see the missionary come out to greet him in a canoe.

Captain: "How on earth did you ever keep them from eating you?"

Missionary: "It was easy. You see, I have a cork leg. As soon as I landed, I pulled up my trousers, cut off a slice and handed it to the chief. He decided I wasn't worth cooking."

★

Mrs.: "Why do you go out on the front porch when I sing? Don't you like my singing?"

Mr.: "It isn't that. I don't want the neighbors to think I am beating you."

★

Two men worked side by side in a War Production Board office in Washington. They never spoke, but each watched the other. One man quit work daily at 4 o'clock. The other toiled until 6 or later.

Some weeks passed. Then the harder working of the two approached the other.

"I beg your pardon," he said. "Do you mind telling me how you clean up your work every day at 4 o'clock?"

"Not at all," said the other man. "When I come to a tough piece of detail, I mark it, 'Refer to Commander Smith,' I figure that, in an outfit as large as this, there is sure to be a Commander Smith. And I must be right; none of those papers comes back to me."

The harder worker started to remove his coat.

"Brother," he said, "prepare for action. I'm Commander Smith."

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A train operated by a Norwegian engineer starts to New York from Albany just as a train with a drunken engineer leaves New York for Albany. There's only one track, no switches or sidings, yet the trains do not collide. Why?

Because Norse is Norse and Souse is Souse and never the twain shall meet.